

# SUPPORTIVE TRANSITIONAL EMANCIPATION PROGRAM

## TRANSITIONAL INDEPENDENT LIVING PLAN (STEP TILP) FOR 18 UP TO 21 YEARS OLD

### PERSONAL DATA

START DATE OF PROGRAM:		COMPLETION DATE:		
NAME:		SSN:	DATE OF BIRTH:	AGE:
		— —		
COUNTY OF THE LAST HELD DEPENDENCY/WARDSHIP:		NAME OF LAST SOCIAL WORKER:		
CURRENT ADDRESS:	CITY:	COUNTY:	STATE:	ZIP:
				TELEPHONE:
				( )
MAILING ADDRESS IF DIFFERENT:	CITY:	COUNTY:	STATE:	ZIP:
				OTHER TELEPHONE:
				( )
TRIBAL AFFILIATION:	IF YES, NAME OF TRIBE:	ETHNICITY:		LANGUAGE:
<input type="checkbox"/> YES <input type="checkbox"/> NO				
EMANCIPATED FROM:				EMANCIPATION DATE:
<input type="checkbox"/> FOSTER CARE <input type="checkbox"/> PROBATION <input type="checkbox"/> RELATIVE CARE				
THE COUNTY WILL CHECK IN WITH ME:				
<input type="checkbox"/> MONTHLY <input type="checkbox"/> QUARTERLY <input type="checkbox"/> EVERY 6 MONTHS <input type="checkbox"/> ANNUALLY <input type="checkbox"/> OTHER(SPECIFY):				
CURRENT IDENTIFICATION:		MY PRIMARY SERVICE PROVIDER IS:		
<input type="checkbox"/> CA ID CARD <input type="checkbox"/> CA DRIVER'S LICENSE <input type="checkbox"/> PASSPORT <input type="checkbox"/> VISA				

### EDUCATION

#### Completed schooling

Type of education I have completed:

- ☐ Up through 9th Grade    ☐ Up through 10th Grade    ☐ Up through 11th Grade    ☐ Up through 12th Grade  
☐ High School Diploma    ☐ GED    ☐ Vocational Education    ☐ Community College  
☐ 4 year College/University    ☐ Other (specify):

School Attended: \_\_\_\_\_

Course of Study: \_\_\_\_\_ Date Completed: \_\_\_\_\_

#### Current schooling

Type of education I am currently enrolled in:

- ☐ High School    ☐ GED Courses    ☐ Vocational Education    ☐ Community College  
☐ 4 year College/University    ☐ Other (specify):

School Attended: \_\_\_\_\_

Course of Study: \_\_\_\_\_ Projected Completion Date: \_\_\_\_\_

Proof of Enrollment (attach): ☐ Report Card ☐ School Transcripts ☐ Proof of Registration☐ Other (specify): \_\_\_\_\_

#### Educational Goals

Grade Point Average: \_\_\_\_\_

During my time in STEP, my educational goals are:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

My plan to achieve these goals are:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

My educational Service Provider is: \_\_\_\_\_

They will help me achieve these goals by:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Date projected to complete my educational goals: \_\_\_\_\_ Proof that I am achieving my education goals (*attach*):

I have attached the following documents to verify the progress I've made toward my educational goals: \_\_\_\_\_

### Financial Aid/Scholarship Information

I currently receive (*please mark all that apply*):

☐ Financial Aid ☐ Scholarship ☐ Grant ☐ Other: \_\_\_\_\_

Please specify what is received:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

If I do not currently have Financial Aid/scholarship information and would like to obtain information about available options my Service Provider will help me achieve this by:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### Summer Plans

During the summer break, my plans are:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### Additional Information

Other information/interests that help me to achieve my educational goals (*ie. volunteer work, sport teams, etc.*):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### EMPLOYMENT (Current Employment)

START DATE: _____		PLACE OF EMPLOYMENT: _____	
JOB TITLE: _____		JOB RESPONSIBILITIES: _____	
CURRENT WORK SCHEDULE: _____		HOURS I WORK PER WEEK: _____	
SHIFT I WORK: _____		RATE OF PAY: _____	
<input type="checkbox"/> Day <input type="checkbox"/> Swing <input type="checkbox"/> Evening <input type="checkbox"/> Grave <input type="checkbox"/> Other ( <i>specify</i> ): _____		\$ _____ per hour	
SUPERVISOR/CONTACT PERSON: _____		TELEPHONE: _____	
PROOF OF EMPLOYMENT ( <i>ATTACH</i> ): _____		( ) _____	

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## Employment History

START DATE:	END DATE:	PLACE OF EMPLOYMENT:
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JOB RESPONSIBILITIES:

START DATE:	END DATE:	PLACE OF EMPLOYMENT:
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JOB RESPONSIBILITIES:

START DATE:	END DATE:	PLACE OF EMPLOYMENT:
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JOB RESPONSIBILITIES:

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## Unpaid Work Experience (*Volunteer Work*)

START DATE:	END DATE:	PLACE OF EMPLOYMENT:
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JOB RESPONSIBILITIES:

START DATE:	END DATE:	PLACE OF EMPLOYMENT:
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JOB RESPONSIBILITIES:

START DATE:	END DATE:	PLACE OF EMPLOYMENT:
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JOB RESPONSIBILITIES:

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## Employment Needs

To achieve my employment goals, I need assistance in the following areas:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

My employment Service Provider is: \_\_\_\_\_

My Service Provider will help me with these needs by: \_\_\_\_\_

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

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## CAREER

### Career Goal

My Career goals are:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

My plans to achieve these goals are:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

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## CAREER

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### Career Goal *(Continued)*

My career Service Provider is: \_\_\_\_\_

My Service Provider will help me achieve my career goals by:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

I am achieving my career goals: ☐ YES ☐ NO

Supporting documentation: \_\_\_\_\_

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## HEALTH COVERAGE

I AM CURRENTLY ON MEDI-CAL: I CURRENTLY HAVE HEALTH COVERAGE: IF YES, MY SOURCE OF COVERAGE:

☐ YES ☐ NO ☐ YES ☐ NO

I CURRENTLY HAVE DENTAL COVERAGE: IF YES, MY SOURCE OF COVERAGE:

☐ YES ☐ NO

I CURRENTLY HAVE VISION COVERAGE: IF YES, MY SOURCE OF COVERAGE:

☐ YES ☐ NO

If I do not have health, dental or vision coverage my Service Provider plans to help me obtain coverage by: \_\_\_\_\_

I would like information on the following: ☐ Drug Rehabilitation ☐ Alcohol Rehabilitation ☐ Tobacco Cessatio  
☐ None ☐ Other (specify): \_\_\_\_\_

My health Service Provider is: \_\_\_\_\_

My Service Provider will assist me by: \_\_\_\_\_

Additional health needs:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

My Service Provider will assist me by: \_\_\_\_\_

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## HOUSING

My current living situation is (check all that apply): ☐ With spouse ☐ With minor children

☐ Alone renting an apartment or house ☐ Transitional Housing ☐ Host Family ☐ With parent

☐ With roommate renting an apartment or house ☐ With relatives ☐ College Dorm ☐ Homeless

☐ Shelter ☐ Section 8 Vouchers ☐ Unsafe ☐ Temporary ☐ With friends

☐ Other (specify): \_\_\_\_\_

My current living situation is safe: ☐ YES ☐ NO

If NO, my Service Provider will help me gain a safe living environment by: \_\_\_\_\_

I have changed residences during the previous 12 months because: \_\_\_\_\_

I am currently on the transitional housing waiting list: ☐ YES ☐ NO

I am currently on the Section 8 voucher waiting list: ☐ YES ☐ NO

My housing needs are: \_\_\_\_\_

My housing Service Provider is: \_\_\_\_\_

My Service Provider will assist me by: \_\_\_\_\_

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**DRIVERS LICENSE**

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I hold a valid California Driver License: ☐ YES ☐ NO

If NO, please explain: \_\_\_\_\_

My plans to obtain one are: \_\_\_\_\_

My Service Provider will assist me by: \_\_\_\_\_

My Service Provider helping me obtain my driver's license is: \_\_\_\_\_

I currently have car insurance: ☐ YES ☐ NO

If NO, please explain: \_\_\_\_\_

My plans to obtain insurance are: \_\_\_\_\_

My Service Provider will assist me by: \_\_\_\_\_

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**SUPPORT NETWORK**

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I have a network of supportive adults to whom I can turn to in times of needs. They include:

Relationship	Name of Supportive Adult	Contact #
Mentor	NAME: _____	(   )   -
Relative	NAME: _____	(   )   -
STEP Provider	NAME: _____	(   )   -
Social Worker	NAME: _____	(   )   -
Friend	NAME: _____	(   )   -
THP + Provider	NAME: _____	(   )   -
ILP Staff	NAME: _____	(   )   -
Former Foster Parent	NAME: _____	(   )   -
Therapist	NAME: _____	(   )   -
Other	NAME: _____ RELATIONSHIP: _____	(   )   -
Other	NAME: _____ RELATIONSHIP: _____	(   )   -
Other	NAME: _____ RELATIONSHIP: _____	(   )   -
Other	NAME: _____ RELATIONSHIP: _____	(   )   -
Other	NAME: _____ RELATIONSHIP: _____	(   )   -
Other	NAME: _____ RELATIONSHIP: _____	(   )   -
Other	NAME: _____ RELATIONSHIP: _____	(   )   -

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**FINANCIAL**

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My sources of income include: ☐ Work ☐ STEP Payment ☐ SSI ☐ Trust Account ☐ CalWORKs  
☐ Other (specify): \_\_\_\_\_

I currently have a: ☐ Checking Account ☐ Savings Account ☐ Neither

My plans to pay bills and manage money are: ☐ Open a Checking Account ☐ Open a Savings Account

☐ Money Order's ☐ Cashier's Checks ☐ Other (specify): \_\_\_\_\_

Signing this contract means that we will all work to complete the steps necessary to help the participant meet his/her goals. The form shall be updated at least annually. The participant is responsible for informing the county whenever changes occur that affect payment of aid, including changes in address, living circumstances, educational/career/training programs. The participant understands that failure to follow the plan outlined herein may result in forfeiture of the STEP payments.

STEP PARTICIPANT	DATE
SERVICE PROVIDER	DATE
COUNTY REPRESENTATIVE	DATE

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## PERSONAL DATA FORM

These questions are for data collection purposes only.

Your answers do not affect your eligibility for STEP and you are not required to answer the questions in order to receive STEP.

1. Current Marital Status: ☐ Never Married ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated
2. Number of children: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
3. Since I turned 18 years old I was incarcerated: ☐ YES ☐ NO

### PERSONAL INFORMATION NOTICE

Pursuant to the Federal Privacy Act (P.L. 93-679) and the information Practices Act of 1977 (Civil Code Sections 1798, et. seq.), notice is hereby given for the request of personal information by this form. The requested personal information is voluntary. The principal purpose of the voluntary information is to facilitate the processing of this form. The failure to provide all or any part of the requested information may delay processing of this form. No disclosure of personal information will be made unless permissible under Article 6, Section 1798.17 of the IPA of 1977. Each individual has the right upon request and proper identification, to inspect all personal information in any record maintained on the individual by an identifying particular. Direct any inquiries on information maintenance to your IPA Forms Officer.